COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2025 IMPLEMENTATION STRATEGY

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ABOUT GRADY HEALTH SYSTEM

Grady Health System (GHS) is one of the largest safety net health systems in the United States. GHS is the only Level 1 trauma center in Atlanta verified by the American College of Surgeons and serves a population of over 1.8 million residents primarily in DeKalb and Fulton counties. GHS provides a range of critical and intensive care, including the Marcus Stroke and Neuroscience Center and the Walter L. Ingram Burn Center. GHS also provides primary care services at the main hospital, one walk-in center, and six primary care centers throughout Fulton and DeKalb counties. Table 1 provides a list of GHS's primary care centers.

Table 1. GHS Primary Care Centers

GHS Primary Care Centers	County
Asa G. Yancey Health Center	Fulton
Brookhaven Health Center	DeKalb
Camp Creek Comprehensive Care Center	Fulton
East Point Health Center	Fulton
Kirkwood Health Center	DeKalb
North Fulton Health Center	Fulton
Primary Care Center at Grady Memorial Hospital	Fulton

GHS continues to maintain its strong commitment to the healthcare needs of Fulton and DeKalb counties' underserved while also offering a full range of specialized medical services for all segments of the community.

Grady Memorial Hospital is an internationally recognized teaching hospital staffed by faculty from Emory University School of Medicine and Morehouse School of Medicine. The hospital has grown considerably from its original 110-bed facility to a hospital with more than 900 licensed beds. Twenty-five percent of all physicians practicing medicine in Georgia received training at Grady.

Some of Grady's other services include a Diabetes Center, Burn Center, the Georgia Cancer Center of Excellence, and 911 EMS. It is also a designated Regional Perinatal Center, and 100 other subspecialty services. Moreover, GHS houses Georgia's Poison Center, a 24-hour Rape Crisis Center, a comprehensive 24-hour Sickle Cell Center, the largest nursing home in the state of Georgia, Nurse Advice Lines, and has one of the top three HIV/AIDS outpatient clinics in the country.

GHS addresses the healthcare needs of the community locally, regionally, and statewide through multiple efforts. GHS has a steadfast commitment to the underserved and a mission to "improve the health of the community by providing quality, comprehensive healthcare in a compassionate, culturally competent, ethical, and fiscally responsible manner." While its primary geographic service area consists of Fulton and DeKalb counties, GHS serves thousands of other residents in the Atlanta area and throughout Georgia. In its 2021 Annual Report, Grady reports admitting nearly 35,000 patients, responding to almost 170,000 911 calls in Atlanta and South Fulton, and providing almost 700,000 virtual and in-person visits.[1]

Grady also supported Georgia's COVID-19 response by performing approximately 104,000 COVID PCR tests and 50,000 COVID vaccinations.[1]

More than 60% of GHS's revenue is generated through Medicare and Medicaid reimbursement.[2] Still, millions of dollars in indigent and charity care are provided monthly – expensive care that GHS must shoulder. In 2020, Grady provided more than $500 million in indigent and charity care (including non-reimbursed dollars). Although vital to GHS's survival, Fulton and DeKalb taxpayer support constitutes a relatively small portion of GHS's operating budget. Charity medical care, including essential supplies and equipment, is provided at all levels of the health system and across all specialty areas.

ABOUT THE GHS COMMUNITY

The population of Georgia is one of the fastest growing in the nation. The community served by GHS, Fulton and DeKalb counties, is also projected to grow at a rapid pace. According to 2021 population estimates, these counties have remained in the top four most populous in the state (Fulton #1, DeKalb #4) since 2016. When compared to Georgia, these counties are younger, more diverse, and higher income earning.

The African American population constitutes 52.8% of the population in DeKalb County and 43.1% in Fulton County. Comparatively, African American residents make up less than one-fifth of the total state population. The White population is less than 40% in each county, and the Hispanic population makes up 8.4% and 7.2% of the population in DeKalb and Fulton Counties, respectively. Since 2019, when the last community health improvement plan was authored, the Hispanic population has decreased slightly. During the same period, the population with limited English-speaking skills increased in both counties, and it remains higher in DeKalb County when compared to the state (8.3% and 5.4%, respectively).

The service area's population has remained relatively young, with the median age at 35.9 years in DeKalb and 35.7 years in Fulton. Residents aged 65 years and older make up slightly more than 10 percent of the population in both counties.

Social and economic drivers are significant determinants of an individual's health. Among these factors are education, access to insurance, income, and housing. These factors influence an individual's ability to obtain employment, safe living conditions, nutritious foods, and access healthcare, all which impact health. Poverty has decreased in the GHS service area since the 2019 Community Health Needs Assessment (CHNA). The percentage of the population living at or below the Federal Poverty Level (FPL) in DeKalb County, which is $26,500 for a family of four, decreased from 17.6% to 16.1%.[3] Similarly, poverty decreased in Fulton County from 16.0% to 14.4%. While single-parent families experience the highest rates of poverty throughout the service area, Fulton County shows the starkest contrast between single-parent poverty (31.8%) when compared to all types of families (12.0%). Housing costs have increased dramatically in the service area due to the economic impacts of the COVID-19 global pandemic, and over a quarter of homeowners and over 50% of renters in both counties are paying more than 30% of their income for monthly mortgage or rent payments.

Access to insurance is closely related to poverty and income, as low-income residents are more likely to be uninsured or underinsured. Since 2019, the percentage of uninsured residents decreased throughout the service area. In 2021, 17.1% of adults 19-64 years of age were uninsured in Fulton County, and 11.9% in DeKalb County, compared to 18.1% uninsured statewide, however both counties have census tracts with

uninsured populations above 20%. According to the most recent estimate, 16.5% of Fulton County and 20.8% of DeKalb County are enrolled in Medicaid. Statewide, 19.8% of the total population is enrolled in Medicaid. The lack of access to insurance limits access to healthcare services, and particularly access to preventive services.

COMMUNITY HEALTH NEEDS

In 2016 and 2019, Georgia Health Policy Center conducted a similar CHNA and Implementation Strategy for GHS. When comparing to the previous two CHNAs, there are several notable trends in the 2022 findings.

Notable improvements were made in:
- Cancer incidence and mortality rates
- The number of healthcare providers generally, though safety-net providers remain low
- Poverty
- Unemployment, though rates spiked in 2020 due to the COVID-19 global pandemic
- Insurance rates, but there is no measure of the rate of underinsurance
- Obstructive heart disease
- Rates for STIs
- Respiratory health
- Infant mortality rate

Trends worsened for:
- Obesity and Diabetes morbidity and mortality
- Hypertensive Heart Disease and stroke
- Human Immunodeficiency Virus (HIV)
- Mental health and Behavioral Disorders
- Suicide mortality, specifically in DeKalb County
- Substance abuse and overdose
- Assault (Homicide) morbidity and mortality

The CHNA and the Implementation Strategy development process (described next) were conducted in compliance with the Patient Protection and Affordable Care Act (ACA) federal requirements. These requirements, Section 501(r) of the Internal Revenue Code, require nonprofit hospitals to (a) conduct a community health needs assessment at least once every three years and describe the process and findings and (b) describe in a written community health improvement plan, or Implementation Strategy, the plan to address each identified health need and provide a rationale for the health needs that will not be addressed by the hospital.

GHS conducted the most recent CHNA in 2022 to identify needs and resources in its community. The CHNA examined secondary data and considered input from public health experts, as well as community leaders and representatives of high-need populations in Fulton and DeKalb counties — this included minority groups, low-income individuals, medically underserved populations, and those with chronic conditions. Upon review of the data, GHS used a set of criteria, including importance to stakeholders, relative burden, current GHS capacity, and disparities to identify and prioritize the significant health needs facing the community and documented them in a written CHNA Report.

Based on the primary and secondary analysis completed for the CHNA report, GHS decided on four primary priorities (Figure 1) for new work, investments, and population health team support:

1. Access to Care
2. Social Determinants of Health (SDOH)
3. Mental Health
4. Violence and Injury

Figure 1. Community Health Improvement Priorities

PRIORITY #1

ACCESS TO CARE
- Maximize current capacity of primary care clinics
- Increase care capacity in key geographies
- Adopt care innovations
- Expand community engagement/awareness

PRIORITY #2

SOCIAL DETERMINANTS OF HEALTH
- SDOH screening for all patients across all settings at least annually
- Connect patients to internal and community resources
- Build a network of community-based resources with

PRIORITY #3

MENTAL HEALTH
- Increase access to inpatient and outpatient services
- Enhance services and supports across the health system and community
- Support justice and mental health reform

PRIORITY #4

VIOLENCE & INJURY
- Expand hospital-based violence prevention initiatives
- Continue community leadership and engagement
- Expand the Trauma Recovery Center
- Support growth of Cardiff program and network

In addition to the primary priorities, GHS also identified four secondary priorities in areas that continue to be important to Grady and the community:

- HIV/STIs
- Cancer
- Maternal and Child Health
- Cardiovascular Conditions

Robust services and innovative programs already exist for these priority areas; implementation strategies will focus on improving, growing, and funding these programs.

IMPLEMENTATION STRATEGY DEVELOPMENT PROCESS

GHS employed a two-phased approach to prioritize health needs and determine the strategies to address the needs. In the first phase, the GHS Population Health Council (PHC) reviewed and prioritized health needs from the CHNA. The second phase included confirming needs to be addressed and developing strategies to address them using evidence-based strategies and feedback from the PHC work groups and input from Grady Memorial Hospital Management Team / CEO Council.

PHC members used the following criteria to rank health needs that were identified in the CHNA:

- **Comparison to national benchmarks** – *How far is the need from national averages?*
- **Magnitude/scale of the problem** – *How many people are impacted?*
- **Severity of the problem** – *How serious are the consequences if not addressed?*
- **GHS assets** – *Does Grady have relevant expertise and unique assets to address the need?*

Given the commitment to evidence-based approaches, achievable results, and the opportunity to leverage GHS assets and build on the work of partner organizations, Grady considered the following information and databases to identify strategies to address the selected health needs:

- Previous strategies including achieved outcomes
- The Atlanta Regional Collaborative for Health Improvement (ARCHI) Playbook[4]
- The Guide to Community Preventive Services[5]

The Council discussed strategies for implementation over the next three years. This information is detailed in the Implementation Strategy tables that follow. Within each table, the strategies are organized by type of intervention, the description each intervention, and the target population of the strategy.

The strategies outlined in the tables include both ongoing programs and services, as well as new initiatives planned for the next three years. Many of the ongoing programs and services were established only during the previous three-year period. Efforts in the upcoming three-year period will focus on growing, optimizing, and ensuring sustainability of these programs. Including these programs in the Implementation Strategy allows Grady to continue prioritizing these critical activities and will ensure that they have the greatest community health impact. Finally, the evidence supporting the identified implementation strategies is listed in the Anticipated Impact section below each table.

Based on the health needs prioritization and feedback from the PHC, goals, strategies, target population, and expected outcomes for each prioritized health need were drafted. The primary and secondary needs that GHS has chosen to track and measure are noted, and rationale is provided in the section following the Implementation Strategy.

IMPLEMENTATION STRATEGY

The CHIP will be implemented over the next three years, from January 2023 to December 2025. It will be jointly implemented through collaboration between GHS, partners, and community organizations in the service region. The Implementation Strategy tables in this section detail the three-year plan to address the prioritized health needs in Fulton and DeKalb counties.

According to The Community Guide from the Community Preventive Services Task Force (CPSTF), health exists when individuals have equal opportunities to be healthy. Nearly all the community health needs identified in the CHNA disproportionately affect certain portions of the population. Examples include the rates of chronic disease and homicide deaths are higher in the African American community;[6] people in low-income households and of Hispanic ethnicity are more likely to be uninsured;[6] the HIV epidemic disproportionately affects African American and LGBTQ communities;[7] and, COVID-19 disproportionately impacted persons of color and those living in healthcare professional shortage areas.[8]

As investments are made to address the health needs of our community, it is Grady's underlying priority to promote health equity. While residents in Grady's service area generally have higher income, employment, insurance, housing, and education rates when compared to the state, a closer look at the data by zip/race/ethnicity reveals that both DeKalb and Fulton Counties have geographic pockets where the burden of inequitable SDOH match or exceed those found at the state level. Single female head of household families and African American, Multiracial, and Hispanic residents experience the highest rates of poverty throughout the service area, and while 11.4% of residents are uninsured overall, 13.6% of African American residents and 30.3% of Hispanic residents lack insurance in the service area.

The patients served by Grady in 2021 were 74.6% African American, 8.7% were Hispanic/Latino, 32.5% uninsured, and 21.3% Medicaid-enrolled. Strategies that target Grady's patients will have a significant impact on low-income and minority populations. Moreover, GHS will work to implement community-focused strategies in neighborhoods that represent Grady's patient population, since that is where health inequities persist. As such, health equity strategies spearheaded by Dr. Yolanda Wimberly in the Health Equity Office at GHS are reflected in this implementation plan and are integral to reducing disparities in Grady's community.

In addition to the health-specific strategies previously outlined, GHS is committed to equity as an anchor institution in Atlanta. GHS is a founding member of ARCHI, a coalition of more than 100 public, private, and nonprofit organizations working to improve the region's health. As an active partner, Grady is committed to the ARCHI philosophy of upstream, cross-sector work, with an emphasis on health equity. GHS also has an award-winning Supplier Diversity Program and is a pioneering leader in this work in Atlanta and the healthcare industry. This work is increasing the economic status of women and minority business owners, and their employees in Atlanta and nationwide. Another organizational priority for GHS is participating in regional workforce development programs. GHS will continue to work with partners to increase healthcare training opportunities for low-income individuals and entry-level healthcare staff to build the healthcare workforce, provide opportunities for minority and low-income populations, and ensure the highest quality of care for GHS patients.

Access To Care Implementation Strategy

Priority	Access to Care		
3-Year Goal	Increase access to primary care and preventive services		
Metric	Primary care volume		
Plan			
Strategy	**Description**	**Target Population**	**Grady Lead(s)**
Maximize current capacity of primary care clinics	Ongoing process improvement to ensure efficient operations (slot utilization, access, etc.).	Grady Primary Care	Aiyana Cottman, Rosalyn McLeod, Dr. Carroll
Increase care capacity in key geographies: • Physical locations • Mobile access • Community engagement	Add new outpatient sites to improve access to primary care. Partner with CBOs to establish satellite and mobile clinics, pop-up health screenings, telemedicine/telehealth promotion, and other alternative forms of healthcare access.	West Atlanta Southwest Northlake Chosewood/ Panthersville	Shannon Sale, Dr. Carroll
Care innovations: • Access to telehealth, virtual care, etc. • Patient engagement, education	Expand telehealth, on-demand visits, 24/7 wearables, remote patient monitoring (RPM), app/virtual education/engagement, mobile integrated health (MIH), hospital at home. Expand wrap-around services: PharmDs, RDs, Care Coordinators, Therapists, Peer Counselors, and Community Health Workers.	Medicaid population	Aiyana Cottman, Leslie Marshburn
Community engagement and awareness: Expand community outreach programs for education, workforce development and recruitment, and access.	Develop a workforce pipeline in Grady Health System by teaching learners the skills needed to become aware health professionals and health equity advocates. Educational innovation and community programming to strengthen capacity to educate and innovate through community resources.	K-12 school systems colleges, universities religious and faith-based organizations, community and civic organizations	Dr. Wimberly

According to the Agency for Healthcare Research and Quality, access to care means having the timely use of personal health services to achieve the best health outcomes. This consists of four components: 1) healthcare coverage 2) having a usual source for receiving health services 3) having timely access to care when a need is recognized, and 4) access to a capable, qualified, and culturally competent workforce of providers.[9] Among GHS' 2022 primary priorities access to care is a critical concern and action area.

Access to Care Anticipated Impact

In implementing access to care strategies, the following evidence-based programmatic outcomes can be anticipated:
- Improved access to primary care, quality of discharge, patient satisfaction with care, and hospital readmission rates for patients with chronic diseases.[10]
- Increased community support, engagement, and social capital through strategic partnerships with community stakeholders, organizations, and institutions, leading to better health outcomes and utilization of care services.[11,12,13]
- Enhanced value-based clinical care and disease management through the availability of telemedicine and telehealth visits.[14]
- Increased cancer screenings and better continuity of care and treatment after cancer diagnoses.[15,16]
- Improved birth and maternal health outcomes through the expansion of group prenatal care services.[1718] Action here increases the potential to decrease pre-term and low-birthweight births, and maternal mortality rates among patients.

Social Determinants of Health Implementation Strategy

Priority	Social Determinants of Health (SDOH)		
3-Year Goal	Screen all patients across all settings for SDOH at least annually and connect patients to resources		
Metric	Percent of patients screened for SDOH		
Plan			
Strategy	**Description**	**Target Population**	**Grady Lead(s)**
Screen all patients across all settings for SDOH at least annually	Complete the ambulatory roll out of SDOH screening and expand to inpatient and ED settings. Continue training to ensure patient-centered, culturally competent screening and a sustainable process.	Grady Primary Care Grady Inpatient	Katie Mooney
Utilize MSWs, Navigators, and CHWs along with a technology platform to connect patients to internal and community-based resources	Hire additional CHWs and Navigators to address SDOH needs by connecting to internal and community resources. Partner with MSWs, CHWs, and Navigators to improve effectiveness of community referrals. Utilize a bi-directional online referral platform to connect to community resources.	Patients with identified social needs	Dr. Carroll, Leslie Marshburn, Katie Mooney
Build a network of community-based resources in collaboration with partners	Create meaningful connections with community agencies providing support to Grady patients for SDOH needs. Continuously collaborate with agencies to improve referral processes and service provision. Network and advocate for new partners, expanded programs or more resources.	Patients with identified social needs	Katie Mooney

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Priority	Social Determinants of Health (SDOH)		
	Continue improving, growing partnership with existing housing, transportation, and food partner agencies.		

Social Determinants of Health (SDOH) are the economic, educational, political, and environmental circumstances in which people are born, grow up, live, work, and age. The Healthy People 2030 initiative defines the SDOH categories as:[19]

- Economic stability- reduce household food insecurity and hunger, reduce the proportion of adolescents and young adults who are not in school or working.
- Education access and quality- increase the proportion of high school students who graduate in four years.
- Healthcare access and quality- increase the proportion of people with a usual primary care provider; increase the proportion of adults whose healthcare provider checked their understanding and/or involved them in decisions.
- Neighborhood and built environment- reduce the rate of minors and young adults committing violent crimes.
- Social and community context- increase the health literacy of the population.

SDOH Anticipated Impact

Research suggests that the implementation of these evidence-based strategies can yield the following outcomes:

- Training providers in culturally competent SDOH screening and care will increase provider cultural competence and patient satisfaction, especially for minority populations.[20,21]
- Through increased SDOH screenings, more patients with social needs will be identified for referrals to resources.[22,23,]
- Referrals for SDOH support will connect patients with resources and community agencies to address SDOH needs such as food, transportation and housing and improve health outcomes and health inequities.[24,25, 26]
- Improved access to primary care for people who are homeless and other marginalized communities.[27,28]
- Decreased use of Emergency Department due to health factors related to SDOH.[29]
- Improved trauma care and comprehensive wraparound services structured around patients' experiences and holistic needs.[30]

Mental Health Implementation Strategy

Priority	Mental Health		
3-Year Goal	Increase access to services and enhance services across the health system and community supports		
Metric	Number of outpatient sites, outpatient volume; new service offerings		
Plan			
Strategy	**Description**	**Target Population**	**Grady Lead(s)**
Increase access to services: • Inpatient • Outpatient	Open Med/Psych unit in early 2023. Partner with Fulton County DBHDD to open additional outpatient service sites.	Acute medical/psych SMI in North and South Fulton	Anne Hernandez, Sue Sweat, Sarah Pace
Enhance services and supports across the health system and community: • Housing supports • Integrated BH • Increase use of specialty services	Hotel support to unhoused through use of Peers. Increase application and Housing Supports for GHVP. Expand consultation and treatment for early psychosis and treatment resistant psychosis. Add SU Peers to Primary Care Clinic to address substance use and support medication assisted treatment. Offer neuromodulation Intervention (ECT).	Fulton/DeKalb County Statewide through telehealth Inpatient psych admissions	Anne Hernandez, Sarah Pace Gregory Scott Sue Sweat
Justice and mental health reform	Respond to City of Atlanta Diversion Center Operator proposal and staff center in 2023. Provide support to justice involved through court/jail diversion activities.	Justice involved in City of Atlanta and Fulton County with SMI/SU challenges	Anne Hernandez Marci Tribble

According to the World Health Organization, mental health is a state of well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community.[31] Mental health is not only the absence of mental disorders, but exists

on a continuum which is experienced differently across all individuals. Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment of function, or risk of self-harm.

Mental Health Anticipated Impact

Research suggests that the implementation of these evidence-based mental health strategies can yield the following outcomes:
- Improved outcomes for individuals with addictive disorders through utilization of new technologies such as neuromodulation intervention (ECT).[32]
- Decreased use of Emergency Department visits from individuals experiencing homelessness and mental illness. [29, 33]
- Housing supports will decrease the number of individuals experiencing homelessness in the community and improve health outcomes for those individuals.[34]
- Improved social outcomes for patients through integration of mental health care with social intervention services.[35]
- Increased reach of services for marginalized communities will improve health outcomes.[28]

Violence and Injury Implementation Strategy

Priority	Injury & Violence		
3-Year Goal	Increase the number of people served by injury and violence prevention programs		
Metric	Number of patients served by IVYY and TRC		
Plan			
Strategy	**Description**	**Target Population**	**Grady Lead(s)**
Expand hospital-based violence prevention initiatives	Launch a hospital-based violence intervention program, Interrupting Violence in Youth and Young Adults (IVYY), at Grady to reduce re-injury in Atlanta. Provide comprehensive care to victims of violence including mental health services, social needs support, life skills, legal services, etc. Update and expand safety measures across all facilities to prevent on-campus violence.	Youth and young adults Patients, visitors, employees	Robin Garza, Dr. Randi Smith Kevin August
Continue to be a leader in community engagement, awareness and education	Participate in city and county efforts to prevent violence, including: Mayor's Office initiatives (Violence Reduction city wide review meeting, Midnight Basketball, Violence Reduction Advisory Board), Dekalb County Keeping it REAL, APD National Night Out, Cure Violence Juneteenth Jubilee, etc. Provide professional & community education, including Stop the Bleed training, gun violence awareness & safety training, Shattered Dreams, Bingocize training for falls prevention, patient-directed fall prevention, distracted/impaired driving, and fire/burn prevention and safety. Initiation of injury and violence research program.	Atlanta metropolitan area	Robin Garza, Sarah Parker, Lawrence Blair
Expand the Trauma Recovery Center	Grow volume by expanding patient eligibility criteria (geography, age, etc.). Add more staff including case manager and specialized clinicians. Partner with IVYY to provide mental health services to IVYY patients.	Victims of violence	Ashley Gresham, Diana Cortina-Rodriguez

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Priority	Injury & Violence		
Support growth of Cardiff program and network	Improve injury location data collection process at Grady. Continue DPH data sharing to inform community interventions to reduce injuries. Support growth of local and statewide Cardiff Violence Prevention Model[36] network.		Dr. Wu

According to The Community Guide from the Community Preventive Services Task Force (CPSTF), violence is a serious public health problem that affects people in all stages of life, and many who survive violence suffer physical, mental, and or emotional health problems throughout the rest of their lives.[5] Violence such as physical assaults, sexual violence, and gun-related injuries are common issues in the United States, and adolescents are especially at risk.[37]

Unintentional injuries can be the result of various causes including motor vehicle crashes, falls, drowning and traumatic brain injury and concussion.

Violence and Injury Anticipated Impact

Research suggests that the implementation of these evidence-based violence and injury prevention strategies can yield the following outcomes:
- Improved outcomes for children and adolescents who are at risk of violence or have been victims of violence.[38, 39]
- Increased access and utilization of care and support for individuals who have experienced violence.[40]
- Improved collaboration with Grady, law enforcement agencies, department of public health, and community groups to share violence data and develop violence prevention strategies.[41]

OTHER HEALTH PRIORITIES

Through the prioritization process, GHS identified the health needs that will be considered secondary in the health systems' implementation efforts. The secondary health priorities include:

- HIV/STIs
- Cancer
- Maternal and Child Health
- Cardiovascular Conditions

These areas continue to be priorities for Grady and the communities they serve, and robust services and innovative programs are already being implemented. CHIP strategies will include improving, growing and funding existing work. Additionally, strategies implemented under the primary priorities of Access to Care and SDOH will likely improve outcomes across these areas.

HIV/STIs

In 2020, the number of people living with HIV in the service region totaled almost 25,000 (Fulton County, 16,004, DeKalb County 8,992).[42] One existing GHS initiative that is highly effective for preventing HIV is use of pre-exposure prophylaxis (PrEP) medicine. When taken as prescribed, the Centers for Disease Control and Prevention reports that PrEP reduces the risk of getting HIV from sex by about 99%.[43]

Cancer

Continued coordination of cancer education and screening between GHS and its partners will help ensure those at greatest risk are identified early. The Grady Cancer Center will continue to provide information and education to patients on self-care while in treatment (surgery, chemotherapy, radiation) and into survivorship. The Georgia Comprehensive Cancer Control Consortium (facilitated by Georgia Health Policy Center) can also be a partner in Grady's efforts to reduce cancer rates in the service region.

Maternal and Child Health

It is well known that Georgia has some of the highest rates of maternal mortality in the United States. Grady is a leader in adopting evidence-based strategies to prevent postpartum hemorrhage and pregnancy-related mortality and maternal morbidity. Use of the Centering Pregnancy program is one such strategy that can lower rates of preterm birth and low birthweight for mothers who are at highest risk.[44]

Cardiovascular Conditions

GHS will continue to be proactive in its efforts to reduce cardiovascular health disparities that exist in the female and African American populations. The systems' efforts to increase access to care, expand its Food as Medicine programs, and support of evidence-based programs for blood pressure and A1C control, especially in populations disproportionally impacted by cardiovascular disease, are critical actions.

The table below provides an overview of the secondary priorities and the strategies that will be employed by GHS to achieve improved outcomes over the next three years.

Priority	HIV/STIs, Cancer, Maternal & Child Health, Cardiovascular Conditions			
Plan				
	HIV/STIs	**Cancer**	**Maternal & Child Health**	**Cardiovascular Conditions**
Metric	Retention in care PrEP patient volume	Cancer screening rates	Maternal hemorrhage	BP control A1c control
Strategies				
Continue efforts from 2020-2022 CHIP	Partnership with Mobile Integrated Health (MIH) Program Pre-Exposure Prophylaxis (PrEP) Clinic Food access via Fresh Food Cart and SNAP assistance Black Women First digital patient engagement initiative	Cancer screening (breast, lung, etc.) Mobile mammography Genetic risk assessment program	MIH BP monitoring for post-partum hypertensive moms Centering Pregnancy Program	BP quality improvement initiative Food as Medicine Food Pharmacy, Fresh Food Carts
Leverage Access to Care strategies	Care innovations including access to telehealth, virtual care, etc., and patient engagement and education Community engagement and awareness: expand community outreach programs for education, workforce development and recruitment, and access			
Leverage SDOH strategies	Screen all patients across all settings for SDOH at least annually Build a network of community-based resources in collaboration with partners			

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REFERENCES

[1] Grady Health System. 2021 Annual Report. Accessed 11/20/2022 from:
https://www.corporatereport.com/grady/2021/ar/broadening-our-impact/year-of-extremes-for-grady.php

[2] Grady Health System. Grady Memorial Hospital Consolidated Financial Statements, KPMG Audit Report, 2019 and 2020, p31.

[3] Federal Poverty Level (FPL) https://www.healthcare.gov/glossary/federal-poverty-level-fpl/

[4] The Atlanta Regional Collaborative for Health Improvement (ARCHI). Accessed 11/23/2022 from:
https://archicollaborative.org/wp-content/uploads/2017/09/ARCHI_Playbook_2017.pdf

[5] The Guide to Community Preventive Services. Accessed 11/23/2022 from: https://www.thecommunityguide.org/

[6] Grady Health System and Georgia Health Policy Center. 2022 Community Health Needs Assessment.

[7] Georgia Department of Public Health. HIV Surveillance Fact Sheet, 2019. Accessed 11/23/2022 from:
file:///C:/Users/Debra%20Kibbe/Downloads/HIV_EPI_2019_Fact_Sheet_20210303.pdf

[8] Baltrus PT, Douglas M, Li C, Caplan LS, Blount M, Mack D, Gaglioti AH. Percentage of Black Population and Primary Care Shortage Areas Associated with Higher COVID-19 Case and Death Rates in Georgia Counties. South Med J. 2021 Feb;114(2):57-62.

[9] Agency for Healthcare Research and Quality. Accessed 11/20/2022 from: https://www.ahrq.gov/topics/access-care.html

[10] Kangovi S, Mitra N, Norton L, Harte R, Zhao X, Carter T, Grande D, Long JA. Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities: A Randomized Clinical Trial. JAMA Intern Med. 2018 Dec 1;178(12):1635-1643. doi: 10.1001/jamainternmed.2018.4630. PMID: 30422224; PMCID: PMC6469661.

[11] Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: an updated systematic review. Ann Intern Med. 2011 Jul 19;155(2):97-107. doi: 10.7326/0003-4819-155-2-201107190-00005. PMID: 21768583.

[12] Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington, DC: National Academies Press; 2017 Jan 11. 7, Partners in Promoting Health Equity in Communities.

[13] University of Kansas. Chapter 1. Our Model for Community Change and Improvement. Section 7. Working Together for Healthier Communities: A Framework for Collaboration Among Community Partnerships, Support Organizations, and Funders. Accessed 09/27/2022 from: https://ctb.ku.edu/en/table-of-contents/overview/model-for-community-change-and-improvement/framework-for-collaboration/main.

[14] Barbosa W, Zhou K, Waddell E, Myers T, Dorsey ER. Improving Access to Care: Telemedicine Across Medical Domains. Annu Rev Public Health. 2021 Apr 1;42:463-481. doi: 10.1146/annurev-publhealth-090519-093711. PMID: 33798406.

[15] Yabroff KR, Reeder-Hayes K, Zhao J, Halpern MT, Lopez AM, Bernal-Mizrachi L, Collier AB, Neuner J, Phillips J, Blackstock W, Patel M. Health Insurance Coverage Disruptions and Cancer Care and Outcomes: Systematic Review of Published Research. J Natl Cancer Inst. 2020 Jul 1;112(7):671-687. doi: 10.1093/jnci/djaa048. PMID: 32337585; PMCID: PMC7357319.

[16] Lee T, Ko I, Lee I, Kim E, Shin M, Roh S, Yoon D, Choi S, Chang H. Effects of nurse navigators on health outcomes of cancer patients. Cancer Nurs. 2011 Sep-Oct;34(5):376-84. doi: 10.1097/NCC.0b013e3182025007. PMID: 21242774.

[17] Crockett AH, Heberlein EC, Smith JC, Ozluk P, Covington-Kolb S, Willis C. Effects of a Multi-site Expansion of Group Prenatal Care on Birth Outcomes. Maternal & Child Health Journal. 2019;23(10):1424-1433.

[18] Ickovics JR, Kershaw TS, Westdahl C, et al. Group Prenatal Care and Preterm Birth Weight. Obstetrics & Gynecology. 2003;102(5 part 1):1051-1057.

[19] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Accessed 11/23/2022 from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

[20] Govere L, Govere EM. How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature. Worldviews Evid Based Nurs. 2016 Dec;13(6):402-410. doi: 10.1111/wvn.12176. Epub 2016 Oct 25. PMID: 27779817.

[21] Chung EK, Siegel BS, Garg A, Conroy K, Gross RS, Long DA, Lewis G, Osman CJ, Jo Messito M, Wade R Jr, Shonna Yin H, Cox J, Fierman AH. Screening for Social Determinants of Health Among Children and Families Living in Poverty: A Guide for Clinicians. Curr Probl Pediatr Adolesc Health Care. 2016 May;46(5):135-53. doi: 10.1016/j.cppeds.2016.02.004. Epub 2016 Apr 18. PMID: 27101890; PMCID: PMC6039226.

[22] Buitron de la Vega P, Losi S, Sprague Martinez L, Bovell-Ammon A, Garg A, James T, Ewen AM, Stack M, DeCarvalho H, Sandel M, Mishuris RG, Deych S, Pelletier P, Kressin NR. Implementing an EHR-based Screening and Referral System to Address Social Determinants of Health in Primary Care. Med Care. 2019 Jun;57 Suppl 6 Suppl 2:S133-S139. doi: 10.1097/MLR.0000000000001029. PMID: 31095052.

[23] Bradywood A, Leming-Lee TS, Watters R, Blackmore C. Implementing screening for social determinants of health using the Core 5 screening tool. BMJ Open Qual. 2021 Aug;10(3):e001362.

[24] Bradywood A, Leming-Lee TS, Watters R, Blackmore C. Implementing screening for social determinants of health using the Core 5 screening tool. BMJ Open Qual. 2021 Aug;10(3):e001362. doi: 10.1136/bmjoq-2021-001362. PMID: 34376389; PMCID: PMC8356186.

Grady

[25] Berkowitz RL, Bui L, Shen Z, Pressman A, Moreno M, Brown S, Nilon A, Miller-Rosales C, Azar KMJ. Evaluation of a social determinants of health screening questionnaire and workflow pilot within an adult ambulatory clinic. BMC Fam Pract. 2021 Dec 24;22(1):256. doi: 10.1186/s12875-021-01598-3. PMID: 34952582; PMCID: PMC8708511.

[26] Gundersen C, Ziliak JP. Food Insecurity And Health Outcomes. Health Aff (Millwood). 2015 Nov;34(11):1830-9. doi: 10.1377/hlthaff.2015.0645. PMID: 26526240.

[27] Health Quality Ontario. Interventions to Improve Access to Primary Care for People Who Are Homeless: A Systematic Review. Ont Health Technol Assess Ser. 2016 Apr 1;16(9):1-50. PMID: 27099645; PMCID: PMC4832090.

28 Aldridge RW, Story A, Hwang SW, Nordentoft M, Luchenski SA, Hartwell G, Tweed EJ, Lewer D, Vittal Katikireddi S, Hayward AC. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Lancet. 2018 Jan 20;391(10117):241-250. doi: 10.1016/S0140-6736(17)31869-X. Epub 2017 Nov 12. PMID: 29137869; PMCID: PMC5803132.

[29] Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health. 2019 May;73(5):379-387. doi: 10.1136/jech-2018-210981. Epub 2019 Feb 18. PMID: 30777888; PMCID: PMC6581117.

[30] Berwick D, Downey A, Cornett E, editors. A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury. Washington, DC: National Academies Press; 2016 Sep 12. 6, Delivering Patient-Centered Trauma Care.

[31] Strengthening Mental Health Promotion. Fact sheet no. 220. Geneva, Switzerland: World Health Organization.

[32] Spagnolo PA, Goldman D. Neuromodulation interventions for addictive disorders: challenges, promise, and roadmap for future research. Brain. 2017 May 1;140(5):1183-1203. doi: 10.1093/brain/aww284. PMID: 28082299; PMCID: PMC6059187.

[33] Tinland A, Loubière S, Boucekine M, Boyer L, Fond G, Girard V, Auquier P. Effectiveness of a housing support team intervention with a recovery-oriented approach on hospital and emergency department use by homeless people with severe mental illness: a randomised controlled trial. Epidemiol Psychiatr Sci. 2020 Sep 30;29:e169. doi: 10.1017/S2045796020000785. PMID: 32996442; PMCID: PMC7576524.

[34] Aubry T, Goering P, Veldhuizen S, Adair CE, Bourque J, Distasio J, Latimer E, Stergiopoulos V, Somers J, Streiner DL, Tsemberis S. A Multiple-City RCT of Housing First With Assertive Community Treatment for Homeless Canadians With Serious Mental Illness. Psychiatr Serv. 2016 Mar;67(3):275-81. doi: 10.1176/appi.ps.201400587. Epub 2015 Dec 1. PMID: 26620289.

[35] Barnett P, Steare T, Dedat Z, Pilling S, McCrone P, Knapp M, Cooke E, Lamirel D, Dawson S, Goldblatt P, Hatch S, Henderson C, Jenkins R, K T, Machin K, Simpson A, Shah P, Stevens M, Webber M, Johnson S, Lloyd-Evans B. Interventions to improve social circumstances of people with mental health conditions: a rapid evidence synthesis. BMC Psychiatry. 2022 Apr 28;22(1):302. doi: 10.1186/s12888-022-03864-9. PMID: 35484521; PMCID: PMC9047264.

[36] Centers for Disease Control and Prevention. Cardiff Model Toolkit. Accessed 11/23/2022 from: https://www.cdc.gov/violenceprevention/pdf/cardiffmodel/cardiff-toolkit508.pdf#:

[37] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 09/27/2022 from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/violence-prevention

[38] Ali-Saleh Darawshy N, Gewirtz A, Marsalis S. Psychological Intervention and Prevention Programs for Child and Adolescent Exposure to Community Violence: A Systematic Review. Clin Child Fam Psychol Rev. 2020 Sep;23(3):365-378. doi: 10.1007/s10567-020-00315-3. PMID: 32215777.

[39] McKay MT, Cannon M, Chambers D, Conroy RM, Coughlan H, Dodd P, Healy C, O'Donnell L, Clarke MC. Childhood trauma and adult mental disorder: A systematic review and meta-analysis of longitudinal cohort studies. Acta Psychiatr Scand. 2021 Mar;143(3):189-205. doi: 10.1111/acps.13268. Epub 2021 Jan 18. PMID: 33315268.

[40] Robinson L, Spilsbury K. Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. Health Soc Care Community. 2008 Jan;16(1):16-30. doi: 10.1111/j.1365-2524.2007.00721.x. PMID: 18181812.

[41] Mercer Kollar, L.M., Jacoby, S.F., Ridgeway, G., Sumner, S.A. Cardiff Model Toolkit: Community Guidance for Violence Prevention. Atlanta, GA: Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017.

[42] AIDSVu. Emory University Rollins School of Public Health and Center for AIDS Research, Gilead Sciences, Inc. 2022. Accessed 11/27/2022 from: https://aidsvu.org/.

[43] Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. Accessed 11/27/2022 from: https://www.cdc.gov/hiv/risk/prep/index.html.

[44] Crockett AH, Chen L, Heberlein EC, Britt JL, Covington-Kolb S, Witrick B, Doherty E, Zhang L, Borders A, Keenan-Devlin L, Smart B, Heo M. Group vs traditional prenatal care for improving racial equity in preterm birth and low birthweight: the Centering and Racial Disparities randomized clinical trial study. Am J Obstet Gynecol. 2022 Sep 13:S0002-9378(22)00734-7.